

MISSOURI STATE BOARD OF HEALTH
STANDARD CERTIFICATE OF DEATH

State File No. 2148

FILED FEB 12 1945

Primary Registration District No. 3396

Registrar's No. 2

1. PLACE OF DEATH:

(a) County Douglas
(b) City or town Silaom Springs Richland
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: /
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution. (Specify whether
in this community. years, months or days)

3. (a) PRINT FULL NAME Bessie Lovan

3. (b) If veteran, name war. 3. (c) Social Security No. None

4. Sex Female 5. Color or race White 6. (a) Single, widowed, married, divorced Married
(b) Name of husband or wife. Aaron Lovan 6. (c) Age of husband or wife if alive. years
7. Birth date of deceased April 6, 1874
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
67 0 2 hr. min.

9. Birthplace Silaom Springs, Mo. (City, town, or county) (State or foreign country)

10. Usual occupation Housewife

11. Industry or business

12. Name Jim Smith
13. Birthplace Unknown (City, town, or county) (State or foreign country)

14. Maiden name Lilly Wilson
15. Birthplace Ind. (City, town, or county) (State or foreign country)

16. (a) Informant Isabelle Lovan
(b) Address Silaom Springs, Mo.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof 4-9-41 (Month) (Day) (Year)
(c) Place: burial or cremation Little Zion

18. (a) Signature of funeral director Friends
(b) Address

19. (a) 2/2/42 (Date received local registrar) (b) Thelma Swater (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Douglas
(c) City or town Silaom Springs (If outside city or town limits, write "RURAL")
(d) Street No. (If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month April day 9
year 1941 hour 8: minute P. M.

21. I hereby certify that I attended the deceased from April 1st to
the 9th of April 1941 to. 19. that I last saw him alive on the 9th of April 19. and that death occurred on the date and hour stated above.

Immediate cause of death Brain tumor
of long standing and hemorrhagic
character
Due to J. B. of the tumor

Due to inherited known to
the Dr. Board

Other conditions.
(Include pregnancy within 3 months of death)

Major findings:
Of operations.

Of autopsy

Duration

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work? (Specify type of place) (e) Means of injury

23. Signature Dr. J. A. Osborn (M. D. or other)
Address Richland Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Licensed Embalmer No.....

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.